DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155334	B. WING			C 06/11/2013		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN 46219			11/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE HE APPROPRIATE		
F 000	INITIAL COMMENTS		F	000				
	This visit was for the IN00129110.	Investigation of Complaint						
	Complaint IN00129110 substantiated. No deficiencies related to the allegations are cited. Survey dates: June 10, 11 2013 Facility number: 000227 Provider number: 155334 AIM number: 100267520 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 154 Total: 154							
	Census payor type: Medicare: 36 Medicaid: 101 Other: 17 Total: 154							
	Sample: 3							
	Wildwood was found	·						
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	DE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.